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No. 86-1887

In the Supreme Court of the United States

OCTOBER TERM, 1987

WILLIAM J. MAYERS, ET UX., PETITIONERS

v.

OTIS R. BOWEN, SECRETARY,
UNITED STATES DEPARTMENT OF HEALTH
AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

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QUESTIONS PRESENTED

The Civil Monetary Penalties and Assessment Act (CMPAA), 42 U.S.C. (& Supp. III) 1320a-7a, provides for the imposition of monetary penalties and assessments against persons who submit Medicare claims for items and services that they know, or have reason to know, were not provided as claimed. The questions presented are:

1. Whether the CMPAA is, contrary to Congress's clearly expressed intent, a penal statute.

2. Whether petitioners knew, or had reason to know, that the items and services for which they submitted Medicare claims had not been provided as claimed.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. A1-A11) is reported at 806 F.2d 995. The decision of the Secretary of Health and Human Services (Pet. App. C1-C7) is unreported. We are lodging with the Court a copy of the opinion of the administrative law judge, which is not reproduced in the appendix to the petition for a writ of certiorari and is unreported.

JURISDICTION

The judgment of the court of appeals was entered on December 22, 1986. A petition for rehearing was denied on February 26, 1987 (Pet. App. B1-B2). The petition for a writ of certiorari was filed on May 22, 1987. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. The Civil Monetary Penalties and Assessment Act (CMPAA), 42 U.S.C. (& Supp. III) 1320a-7a, was added to the Social Security Act by the Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2105, 95 Stat. 789. The CMPAA authorizes the Secretary of Health and Human Services to impose civil monetary penalties and assessments against any person who presents, or causes to be presented, a claim for an item or service under the Medicare or Medicaid programs that the person "knows or has reason to know was not provided as claimed." 42 U.S.C. (& Supp. III) 1320a-7a(a). The Secretary may impose on such a person a penalty of "not more than $2,000 for each item or service" falsely claimed and "an assessment of not more than twice the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim." *Ibid.*

The penalty and assessment involved in this case were imposed against petitioners for submitting false claims for reimbursement under Part B of Medicare. Part B of Medicare provides a voluntary subscription program of supplementary medical insurance covering, in general, 80% of the reasonable charges for certain services not covered by Part A of Medi-

care. Eligible beneficiaries are reimbursed under Part B for covered "medical and other health services." 42 U.S.C. 1395k(a)(1). That term is defined to include, inter alia, "physicians' services" and "services and supplies * * * furnished as an incident to a physician's professional service" (42 U.S.C. (& Supp. III) 1395x(s)).

2. Petitioner William Mayers was a licensed chiropractor until his license was revoked by the Florida Department of Professional Regulation in March 1984 (IG Exh. 216). His wife, petitioner Patricia Mayers, assisted him in the operation of three chiropractic clinics in Ft. Myers, Florida. Chiropractic services, with one exception inapplicable here, are not reimbursable under the Medicare program.[1] Petitioners, however, sought to receive Medicare payments for their services. Indeed, "generating Medicare claims was the principal function of [petitioners'] clinics." Pet. App. C3.[2]

In order to obtain Medicare reimbursement, petitioners engaged in a fraudulent scheme to disguise their non-reimbursable chiropractic services as services rendered by a physician or incident to a physi-

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[1] A chiropractor is included within the definition of "physician," thereby permitting reimbursement for his services, but "only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by X-ray to exist) * * *." 42 U.S.C. (& Supp. III) 1395x(r). This case does not involve any claims for reimbursement for chiropractic treatment of this sort.

[2] The Administrative Law Judge found (ALJ op. 9) that petitioners, in order to attract Medicare patients and in clear violation of Medicare guidelines, "advertised that Medicare beneficiaries would receive essentially free medical care at their clinics, by not being charged the standard Medicare co-payment."

cian's service. Pet. App. A5. Petitioners hired a series of three doctors to work at the clinics. "[T]hese doctors were hired for the sole purpose of obtaining the Medicare billing numbers of the physicians,"[3] and each was required, as a condition of employment, to permit rubber stamps to be made bearing a likeness of his or her signature (*ibid.*). The physicians had little contact with the patients, all of whom received standardized chiropractic tests and therapies (*ibid.*). In fact, Mayers specifically informed the doctors that they were not to involve themselves in or interfere with the clinics' chiropractic services (ALJ op. 21).

Despite the noninvolvement of the physicians in the day-to-day chiropractic services provided by the clinics, these services were regularly billed to Medicare as having been rendered by or incident to the services of the three doctors. Mayers' announced policy was to bill Medicare for an "office visit" to one of the physicians "every time [a] patient breathed his air conditioning and walked on his carpet" (ALJ op. 9). Clerical personnel at the clinics—who were specifically warned not to discuss billing practices with the doctors (*id.* at 8)—routinely used the rubber stamps provided by the doctors to complete Medicare claims forms. And they continued to use the stamps of individual doctors even after those doctors had left the clinics' employ. Pet. App. A6. From June 1982 to January 1984, petitioners submitted claims in excess of $1.8 million seeking

[3] Mayers told clinic employees at the outset that he wanted to obtain "a foreign-born physician who neither spoke nor understood English too well, but who could sign documents" (ALJ op. 7). All three physicians were of foreign extraction. Pet. App. C4 n.3.

medicare reimbursement for chiropractic services alleged to have been rendered by, or incident to the services of, the three doctors. Petitioners received payments on these claims in excess of $500,000. Pet. App. C1-C3.

3. In May 1984, the Inspector General of HHS charged petitioners under the CMPAA with submitting claims for Medicare reimbursement for 2,702 items and services when they knew that the items and services had not been provided by, or incident to the professional service of, a physician. The total amount that petitioners claimed for the 2,702 items and services was $145,550, and they received reimbursements on those claims from the Medicare Part B carrier in the amount of $24,697.73. Pet. App. A1-A3. In every instance, the physician on whose account reimbursement was claimed either was not present at the clinic or was not employed by petitioners on the date the item or service was allegedly rendered (ALJ op. 10).[4] Nor were any other licensed medical doctors present or employed by petitioners on these dates. The claims simply reflected petitioners' fraudulent practice of billing their clinics' services to the medical doctor most recently employed by them if no medical doctor was employed at the time the services were rendered. *Ibid.*

After conducting an extensive hearing, the Administrative Law Judge (ALJ) issued a decision on May 14, 1985, finding that the "Inspector General has established that [petitioners'] claims for reimbursement for the 2,702 charged items or services constitute violations of the [CMPAA]" (ALJ op.

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[4] More than 95% of the items and services at issue here were claimed to have been provided on dates after the respective physicians had left the employ of the clinic. IG Exhs. 6, 7, 8.

4-5). The ALJ further concluded that the 2,702 false claims singled out by the Inspector General "were but a small element of a pattern of unlawful behavior by [petitioners]" (*id.* at 5).

The ALJ found that "[t]he evidence in this case clearly establishes that [petitioners] knew that the 2,702 charged items or services were not provided as claimed" (ALJ op. 14). More specifically, he found (*id.* at 18):

> [Petitioners] knew that the items or services at issue were not reimbursable unless they could be represented as having been provided by or supervised by a licensed medical doctor. They knew that none of the charged items or services was provided by or supervised by a licensed medical doctor. They deliberately presented claims to Medicare for the charged items or services in a manner designed to deceive the Carrier into believing that the claims were reimbursable.

As further proof of petitioners' knowing attempt to defraud the Medicare system, the ALJ pointed to petitioners' deliberate efforts to thwart the Inspector General's investigation by forging and backdating documents so as to make it seem that the doctors had specifically ordered and signed for the treatments billed to Medicare. "The record establishes that months after the dates of patients' initial visits to the clinics, and after [the three doctors] had ceased their employment with [petitioners], [petitioners] instructed several of their employees to generate or alter documents to make it appear as if these medical doctors had actually ordered or rendered the items or services at issue" (ALJ op. 18).

In calculating the appropriate penalty for petitioner's "systematic looting of the Medicare trust fund" (ALJ op. 29), the ALJ cited the absence of any "mitigating factors" and the presence of "substantial additional aggravating factors" (*id.* at 5). First, the 2,702 items charged by the Inspector General "represented only the tip of the iceberg" of petitioners' fraudulent scheme, which "enabled them to mulct Medicare of hundreds of thousands of dollars" (*id.* at 21, 27). Second, the ALJ cited the "blatantly unlawful conduct" of petitioners and "the patent falseness of the claims at issue in this case" (*id.* at 5, 29). And, finally, the ALJ cited "[petitioners'] efforts to conceal from investigating agents the nature and scope of their unlawful activities" (*id.* at 5). Out of a maximum penalty of $5,404,000 (2,702 x $2,000) and a maximum assessment of $291,100 (2 x $145,550), the ALJ "determined that an assessment of $291,100 and a penalty of $1,500,000 coupled with a 25 year suspension from the Medicare and Medicaid programs are appropriate in this case" (*ibid.*).[5]

4. The Secretary affirmed the ALJ's decision, concluding that his "findings are fully supported by the record" (Pet. App. C4). The Secretary agreed with the ALJ that petitioners' conduct "can only be characterized as an extremely flagrant abuse of the Medicare program" (*id.* at C2). More specifically, the Secretary noted that the ALJ was correct in finding that there was "clear evidence that [petitioners] knew that their claims were false," and that "[petitioners] attempted to deceive investigative authori-

[5] The suspension, authorized by 42 U.S.C. 1320a-7(c), is not at issue here.

ties by preparing false documents to cover up the lack of involvement of licensed physicians in the tests and treatments provided" (*id.* at C4 n.3). The Secretary also approved the ALJ's conclusion that the 2,702 items or services specifically charged by the Inspector General "represented a small percentage of a much larger pattern of filing false claims for Medicare reimbursement" (*id.* at C3). The Secretary accordingly concluded that petitioners' "exceptions raise no credible basis to revise the findings in the initial decision or to reduce the amount of penalties and assessments or the period of suspension" (*id.* at C5).

5. Petitioners appealed the Secretary's decision to the United States Court of Appeals for the Eleventh Circuit. See 42 U.S.C. 1320a-7a(d). The court of appeals unanimously affirmed. Pet. App. A1-A11. As an initial matter, the court determined (*id.* at A5):

> The evidence presented to the Administrative Law Judge supports the conclusion that: (1) the Mayers operated a clinic designed solely to provide chiropractic services; (2) the services rendered at the clinic were clearly not reimbursable under Medicare, and (3) the Mayers engaged in a fraudulent scheme to disguise these non-reimbursable chiropractic services as services rendered by a physician.

a. The court rejected petitioners' argument that the penalty imposed against them was criminal, rather than civil, and hence that the proceedings against them were constitutionally inadequate. The court, noting that Congress clearly intended the penalty to be civil, found that the amount of the penalty was not so excessive as to make it punitive in pur-

pose or effect and to negate Congress's intent. Pet. App. A6-A9. The court noted that a number of civil statutes provide for a remedy in excess of tangible damages (*id.* at A8):

> [Petitioners are] correct that the civil penalty imposed does exceed the amount that was directly disbursed as a result of [their] fraudulent conduct. [Petitioners], however, fail[] to recognize that each fraudulent claim filed exacts an immense toll from society. Just as punitive damages in tort law or treble damages under antitrust law encompass a civil remedy in excess of the tangible damages sustained by a plaintiff, here the government has made a determination that activities in violation of the CMPAA result in damages in excess of the actual amount disbursed by the government to the fraudulent claimant. Such a legislative determination is not constitutionally infirm.

The court also determined that the amount of the penalty imposed on petitioners did not amount to an unconstitutional application of the CMPAA. The court explained that the "size of the penalty is a direct result of [petitioners'] conduct." Pet. App. A8. Petitioners "chose fraudulently to request payment for 2,702 items," and there were numerous aggravating factors. These included the fact that "the 2,702 fraudulent claims were but a small part of a larger pattern of activity" and that "[petitioners] attempted to deceive investigators by fabricating documents during the course of the investigation." *Id.* at A8-A9.

b. Petitioners made several other arguments, apart from the alleged unconstitutionality of the CMPAA, in an effort to avoid liability even on the

assumption that the statute imposed civil penalties. Despite the statute's clear language imposing liability if a "person knows or has reason to know [that a medical item or service] was not provided as claimed," 42 U.S.C. 1320a-7a(a)(1)(A), petitioners argued that "actual knowledge" was required to establish liability. The court rejected this argument, noting that petitioners failed to cite any authority for the proposition that "actual knowledge" is required before Congress can impose a civil penalty. Pet. App. A9.

The court also rejected petitioners' contention that the CMPAA and its implementing regulations are "vague and ambiguous" (Pet. App. A9). The court noted that the Medicare program explicitly covers only one type of chiropractic service—one not at issue in this case—and that "no individual could reasonably conclude that other services performed by a Doctor of Chiropractic Medicine would be reimbursable" (*id.* at A10). The court also stated that the elaborate scheme employed by petitioners to make it appear that services were provided by medical doctors when they were not, as well as petitioners' efforts to cover up the scheme once it was discovered, "further refute[] their assertion that they believed that all chiropractic services were covered by the Social Security Act" (*ibid.*). Finally, the court rejected as without merit petitioners' claims that (1) the Department of Health and Human Services failed to respond to their inquiry concerning the propriety of their conduct, (2) the ALJ heard evidence beyond the scope of the government's claims, and (3) the ALJ's decision was arbitrary and capricious (*id.* at A10-A11).

ARGUMENT

The decision of the court of appeals is correct and does not conflict with any decision of this Court or of any other court of appeals. In fact, it is consistent with the decision of the only other appellate court that has considered the prospective application of the CMPAA. *Chapman* v. *United States*, No. 85-2557 (10th Cir. June 15, 1987). Further review is therefore not warranted.

1. Petitioners argue (Pet. 16-22) that the CMPAA is a penal statute and, hence, unconstitutional because it fails to provide procedures constitutionally mandated for criminal prosecutions. A similar argument was recently rejected by the Tenth Circuit in *Chapman* v. *United States*, *supra*.[6] Both courts properly concluded that in enacting the CMPAA Congress intended to create a civil remedy for Medicare fraud as an alternative to criminal prosecution and that Congress properly chose the penalty in accordance with that purpose.

The question whether "a particular statutorily defined penalty is civil or criminal is a matter of statutory construction." *United States* v. *Ward*, 448 U.S. 242, 248 (1980); see also *One Lot Emerald Cut Stones* v. *United States*, 409 U.S. 232, 237 (1972); *Helvering* v. *Mitchell*, 303 U.S. 391, 399 (1938). Congress's unambiguous designation of the penalty under the CMPAA as a civil penalty obviously provides strong evidence of Congress's intent. See

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[6] In *Griffon* v. *Dep't of Health & Human Services*, 802 F.2d 146 (1986), the Fifth Circuit held, as a matter of statutory construction, that the CMPAA was not to be given retroactive application. No question as to the constitutionality of the CMPAA was decided in that case.

United States v. *Turkette*, 452 U.S. 576, 580 (1981). Moreover, there is nothing in the legislative history or statutory scheme that is inconsistent with Congress's clearly expressed intent that the CMPAA set forth a civil rather than a criminal penalty.

Petitioners argue (Pet. 17-19) that the CMPAA is a penal statute because Congress intended to reach criminal conduct. That argument, however, simply ignores the numerous occasions on which this Court has held that Congress may impose both a criminal and a civil penalty in respect to the same act or omission. See *United States* v. *One Assortment of 89 Firearms*, 465 U.S. 354, 359-360 (1984); *United States* v. *Ward*, 448 U.S. at 250; *One Lot Emerald Cut Stones* v. *United States*, 409 U.S. at 235; *United States ex rel. Marcus* v. *Hess*, 317 U.S. 537, 549 (1943). See also *United States* v. *Kordel*, 397 U.S. 1 (1970). This Court held almost 50 years ago, for example, that Congress acted constitutionally in imposing discrete civil and criminal penalties for tax fraud. *Helvering* v. *Mitchell*, 303 U.S. at 399; compare 26 U.S.C. 6653(b) (civil fraud) with 26 U.S.C. 7206 (criminal fraud). These cases establish that as long as there is a remedial purpose to support it, Congress may choose to impose a civil monetary penalty as well as criminal sanctions for the same conduct. And Congress's remedial purpose is evident in the CMPAA. The statute is intended to reimburse the government for losses incurred as a result of false Medicare and Medicaid claims and for expenses incurred in investigating such claims, as well as to facilitate the operation of the Medicare and Medicaid programs by deterring others from making false claims. Pet. App. A6-A8.[7]

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[7] That deterrence is also a goal of criminal statutes does not mean that Congress may not similarly use civil penalties to

Petitioners further argue (Pet. 19-22) that the amount of the penalty authorized by the CMPAA and imposed against them is so punitive as to convert the CMPAA into a criminal statute. But the amount of the penalty is large only because petitioners' fraud was great. This Court has held that "[o]nly the clearest proof that the purpose and effect of the forfeiture are punitive will suffice to override Congress' manifest preference for a civil sanction." *United States* v. *One Assortment of 89 Firearms*, 465 U.S. at 365 (original quotation marks omitted). No such proof exists with respect to the CMPAA. See *Chapman* v. *United States*, slip op. 11-12.

This Court has repeatedly upheld monetary penalties designated by Congress as civil sanctions against contentions that they were punitive in effect and hence had to be considered criminal in spite of Congress's intent. See, *e.g.*, *United States* v. *One Assortment of 89 Firearms*, 465 U.S. at 362-366; *United States* v. *Ward*, 448 U.S. at 248-251; *Rex Trailer Co.* v. *United States*, 350 U.S. 148, 151-154 (1956); *United States ex rel. Marcus* v. *Hess*, 317 U.S. at 548-552; *Helvering* v. *Mitchell*, 303 U.S. at 402-403; *Chicago, B. & Q. Ry.* v. *United States*, 220 U.S. 559, 577-579 (1911); *Oceanic Steam Navigation Co.* v. *Stranahan*, 214 U.S. 320, 338-339 (1909); *Hepner* v. *United States*, 213 U.S. 103, 108-111 (1909). Petitioners have not suggested any unique

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deter persons from interfering with federal policies and programs. See, *e.g.*, *National Independent Coal Operators' Ass'n* v. *Kleppe*, 423 U.S. 388, 401 (1976); *United States* v. *ITT Continental Baking Co.*, 420 U.S. 223, 232 (1975); *Oceanic Steam Navigation Co.* v. *Stranahan*, 214 U.S. 320, 337-338 (1909).

features of the CMPAA that would distinguish petitioners' challenge here from those rejected by this Court in the above-cited cases.

Petitioners do assert (Pet. 22) that the penalty under the CMPAA is disproportionate to the damages sustained by the government. But it is well settled that a civil penalty need not be limited to the amount of the government's actual damages. See *Chapman* v. *United States*, slip op. 11-12; see also *United States ex rel. Marcus* v. *Hess*, 317 U.S. at 550 (recovery of penalty plus double damages for filing false claims); *Helvering* v. *Mitchell*, 303 U.S. at 401 (50% addition to tax deficiency if any portion of the deficiency is due to fraud); *United States* v. *One Lot Emerald Cut Stones*, 461 F.2d 1189 (5th Cir.), aff'd, 409 U.S. 232 (1972) (forfeiture of goods for violating customs laws by failing to declare goods valued at about $50,000, where duty on the goods would have been $335.89); *Toepleman* v. *United States*, 263 F.2d 697 (4th Cir.), cert. denied, 359 U.S. 989 (1959) (monetary penalties of $164,000 and $60,000 assessed under the False Claims Act despite absence of any calculable damages).

The amount of money that petitioners succeeded in wrongfully extracting from the Medicare program before getting caught is not a true measure of the damages suffered by the government. Medicare, by necessity in light of its size, is run—like the federal tax system—largely on the honor code. There is a huge cost involved in ferreting out fraud over and above the amounts actually obtained by the wrongdoers. Pet. App. A8. Congress could reasonably set a monetary penalty of $2,000 per false item or service claimed, plus an assessment of double the amount fraudulently sought, without regard to how much the

wrongdoer actually profited, in order to ensure that the government is made completely whole and to deter others from committing similar acts. See *United States ex rel. Marcus* v. *Hess*, 317 U.S. at 549-551.

The amount of the penalty and assessment imposed on petitioners was less than a third of that authorized by the CMPAA.[8] A penalty and assessment of $5,695,100 would have been permitted by the statute. The ALJ's decision to impose a penalty and assessment of $1,791,100 was fully justified in light of the numerous aggravating factors present here. The 2,702 items or services charged by the Inspector General constituted "only a small portion of a pattern of claims for items or services by [petitioners] that [petitioners] knew were not provided as claimed." ALJ op. 21. Petitioners billed Medicare for fees in excess of $1.8 million, falsely attributed as services rendered by the three doctors, and petitioners were reimbursed over $500,000 for these alleged services (*id.* at 9). Moreover, the submission of the false claims was not the consequence of an innocent mistake, but was part of a "systematic looting of the Medicare trust fund," carried out over a lengthy period of time, which enabled petitioners "to mulct Medicare of hundreds of thousands of dollars" (*id.* at 21, 29). In addition, when investigators began to catch up with their scheme, petitioners forged and backdated documents in an effort to mislead the investigators into thinking that the services had been provided as claimed. Given the numerous and severe aggravating factors present in this case, the remedial purpose of the statute was properly served by im-

[8] In *Chapman*, the penalty imposed was 57% of the maximum amount authorized by the statute. Slip op. 8.

posing a civil monetary penalty commensurate with the scheme perpetrated by petitioners to defraud the Medicare program of funds needed for its continued operation.

2. Petitioners appear to argue (Pet. 12-16) that, even if the CMPAA is not a penal statute, the statutory standard of knowledge or intent necessary for a finding of liability—that the "person knows or has reason to know [that an item or service] was not provided as claimed" (42 U.S.C. 1320a-7a(a)(1)(A))—is constitutionally deficient. This argument seems to be based on the proposition that a specific intent to defraud is necessary before a civil monetary penalty may be imposed. Petitioner cite no support for such a proposition, and, indeed, there is none. Congress may make a legislative judgment as to what intent requirement is appropriate. Indeed, this Court has upheld civil monetary penalties and forfeitures under statutes that do not require the government to prove any scienter on the part of the violator. See *United States* v. *Ward*, 448 U.S. 242, 244-246 (1980); *id.* at 256 (Blackmun, J., concurring); *One Lot Emerald Cut Stones* v. *United States*, 409 U.S. 232 (1972) (per curiam). In the CMPAA, Congress explicitly stated the intent requirement that it deemed appropriate. As the court of appeals concluded (Pet. App. A9), that intent requirement is clear and was clearly satisfied in this case.

In any event, petitioners' argument on this point is entirely hypothetical, since this case does not present the question whether the government may impose a civil penalty without a finding of "actual knowledge." The Secretary specifically affirmed the finding of the ALJ that petitioners "knowingly submitted false claims." Pet. App. C2; ALJ op. 19. As described above (and in much greater detail in the

ALJ's decision),[9] the record amply supports that finding. Petitioners set up a scheme under which Medicare was routinely billed for services that could not conceivably be said to have been rendered by a physician or to have been incident to a physician's professional service.[10] The physicians under whose names the bills were submitted were either no longer employed by petitioners or were not at the clinic when the services in question were rendered (ALJ op. 10).[11] And once petitioners learned that HHS

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[9] Because petitioners have not included the ALJ's decision in the appendix to their petition, we are separately lodging a copy of that decision with the Court. Even a cursory reading of that decision eliminates any doubt that petitioners knowingly and intentionally sought to defraud Medicare. See, *e.g.*, ALJ op. 5, 7, 9, 12-14, 17-19.

[10] Petitioners' suggestion (Pet. 10 n.10) that a chiropractor could be considered a physician for purposes of the claims submitted is without any support. As the court of appeals held (Pet. App. A10):

> [T]he Social Security Act unambiguously provides that a chiropractor's services are not routinely covered. Such services are covered "only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by X-ray to exist) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided." 42 U.S.C. § 1395x(r) (1982). In light of the explicit detail in which Congress narrowly defined reimbursable chiropractic services, no individual could reasonably conclude that other services performed by a Doctor of Chiropractic medicine would be reimbursable.

[11] These physicians were selected, in the first place, because they did not speak English well and would therefore be less likely to understand and object to petitioners' billing practices. ALJ op. 7.

officials were investigating their claims, they took elaborate measures, including the falsification of documents, to mislead the investigators (*id.* at 18). In short, petitioners' scheme abounded with the badges of fraud, and they would be liable for civil penalties even if the CMPAA required a showing of scienter, which it plainly does not.

Finally, petitioners contend (Pet. 11-16) that review by this Court is warranted because the court of appeals, at one point in its decision (Pet. App. A9), equated the statutory intent standard "knows or has reason to know" with "knew or should have known." We doubt that the court of appeals can be said to have committed error in this respect, since it quoted the statutory standard correctly (*id.* at A9) and was, in the passage to which petitioners refer, merely summarizing the ALJ's findings and the gist of petitioners' argument. In any event, if there was any error, it was quite plainly harmless. If one assumes that there is a difference between the phrases "had reason to know" and "should have known," it is that the latter term implies that the actor has a duty to ascertain all pertinent information, while the former refers to the actor's having information from which a person of reasonable intelligence would infer that a certain fact exists. This possible distinction between the two terms, however, has absolutely no bearing on the outcome of this case. The government's case against petitioners did not rest on the theory that petitioners negligently failed to ascertain information. Rather, as described above, the record establishes that petitioners had actual knowledge that the claims they were submitting were false. This case therefore presents no question as to

the content of the "reason to know" branch of the statutory formula.[12]

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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[12] Petitioners err in asserting (Pet. 3, 11) that the court of appeals' decision in this case "has since been directly contradicted and rejected by the Secretary." In *Inspector General* v. *Silver*, No. C-19 (HHS Grant Appeals Bd. Apr. 27, 1987) (*reprinted in* Pet. App. D1-D31), the Secretary posited a "subtle distinction" between the "reason to know" standard and the "should know" standard, stating that the court of appeals in the instant case had confused the two terms by treating them "as if they were equivalent." Pet. App. D30, D31. The Secretary went on to note, however, that the instant case "involves a mundane case of clear fraud * * * and [that] the court's 'error,' such as it was, had no [e]ffect on its holding" (*id.* at D30). Thus, far from repudiating the decision below, the Secretary specifically approved the court's holding (*id.* at D23, D30).

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